STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	010610	A. BUILDING: _____ B. WING _____	C 10/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKEDALE MICHIGAN CITY	1400 E COOLSPRING AVE MICHIGAN CITY, IN 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00183661. Complaint IN00183661- Substantiated. No deficiencies related to the allegation are cited. Survey date: October 14, 2015 Facility number:010610 Provider number: 010610 AIM number: N/A Census bed type: Residential: 67 Total: 67 Census payor type: Other: 67 Total: 67 Sample: 4 Brookdale Michigan City 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00183661. Quality review completed by 26143, on October 15, 2015.	R 000		